NEW JERSEY
INDIVIDUAL HEALTH COVERAGE PROGRAM &
SMALL EMPLOYER HEALTH BENEFITS PROGRAM
20 West State Street, 10th Floor
P.O. Box 325
Trenton, NJ 08625
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NOTICE OF ANNUAL FILING REQUIREMENTS FOR NEW JERSY IHC & SEH PROGRAM ASSESSMENTS ACTION REQUIRED BY MARCH 1, 2001

TO: **PROPERTY AND CASUALTY CARRIERS, LIFE AND ACCIDENT AND HEALTH INSURANCE CARRIERS, HEALTH MAINTENANCE ORGANIZATIONS, AND HEALTH SERVICE CORPORATIONS**
FROM: **New Jersey Individual Health Coverage ("IHC") Program Board & New Jersey Small Employer Health Benefits ("SEH") Program Board**
RE: **Annual Filing of Market Share Reports or Non-member Certifications**
DATE: **January 19, 2001**

Please read this memorandum and applicable regulations carefully before completing any of the enclosed forms.

IHC Program

Carriers which report accident and health premium to the New Jersey Department of Banking & Insurance ("DOBI") for calendar years 1999 or 2000 are required to provide the New Jersey Individual Health Coverage Program ("IHC") Board with **either** a Market Share Report *or* a Certification of Non-member Status depending on whether the carrier is a Member of the IHC Program; carriers should not complete both forms. Copies of both reports are attached hereto. **If the IHC Board does not receive an accurate Market Share Report from a Member by the March 1, 2001 deadline, or has not granted an extension for such a filing, the Board will provide the DOBI with a referral for enforcement. Further, please note that all Market Share Reports may be subject to audit and a carrier should be prepared to support such an audit**. **Non-members must file a Certification of Non-member Status by March 1, 2001 in order to avoid being considered a Member and being assessed based on the carrier's entire accident and health premium reported on its annual statement blank.** Carriers which do not report accident and health premium for 1999 and 2000 are not required to provide the IHC Board with either filing.

Pursuant to the Individual Health Insurance Reform Act of 1992, ("IHC Act"), N.J.S.A. 17B:27A-2 et seq., and regulations promulgated thereto and set forth at N.J.A.C. 11:20-1.1 et seq., all carriers with health benefits plans inforce during 1999 and 2000, covering *large groups, small groups, or individuals* in New Jersey, are subject to assessment by the IHC Board.

SEH Program

Carriers which report accident and health premium in 2000 are required to provide the Small Employer Health Benefits Program ("SEH") Board with either a Market Share Report *or* a Certification of Non-member Status. Carriers should not complete both forms. Copies of these reports are attached hereto. **If the SEH Board does not receive an accurate Market Share Report from a Member by the March 1, 2001 deadline, or has not granted an extension for such a filing, the Board will provide the DOBI with a referral for enforcement. Further, please note that all Market Share Reports may be subject to audit and a carrier should be prepared to support such an audit. Non-members must file a Certification of Non-member Status by March 1, 2001 in order to avoid being considered a Member and being assessed based on the carrier's entire accident and health premium reported on its annual statement blank**. Carriers which do not report accident and health premium for 2000 are not required to provide the SEH Board with either filing.

Pursuant to the Small Employer Health Benefits Act of 1992, ("SEH Act"), N.J.S.A. 17B:27A-17 et seq., and regulations promulgated thereto and set forth at N.J.A.C. 11:21-1.1 et seq., carriers with *inforce small employer health benefits plans in New Jersey* are subject to assessment by the SEH Board.

Filing Requirements for IHC and SEH Programs

If a carrier reports accident and health premium to the DOBI, it is presumed to be subject to assessment based on the *entire* amount(s) reported to the DOBI, unless the carrier files either a:
(1) Non-member Certification which explains that the entity is not a "carrier" or why all the reported accident and health premium is not subject to assessment. You must list the types of coverage which make up the amount reported to the DOBI; an answer of "none" or "not applicable" is not a sufficient answer.

For the IHC Program, completion of a non-member certification means that the carrier had no health insurance of any kind, group or individual, inforce covering New Jersey residents, or employers, whether directly or through a trust, association, or multiple employer arrangement in calendar years 1999 and 2000.

For the SEH Program, this means that the carrier had no small employer health coverage, whether directly or through a trust, association, or multiple employer arrangement of any kind in force during 2000; or
(2) Market Share Report (Exhibit K for IHC; Exhibit CC for SEH), which shows what portion of the reported premium is subject to assessment. Figures reported in the market share reports must correspond to a carrier's NAIC statement blank. Carriers in the individual market must also provide information about enrollment of "non-group persons." Please note that NJ KidCare Part A is an expansion of Medicaid and enrollment should be counted accordingly.

Affiliated carriers filing Market Share Reports must submit both a combined Market Share Report and a Market Share Report for each individual affiliate.

The IHC and SEH Programs are separate State agencies, with independent assessment authority, and different criteria for assessment. Please read the rules carefully before filing. If you have any questions, please let me know.

Wardell Sanders
Executive Director

The following excerpts from the **IHC Program** regulations are set forth below to assist you in completion of the Non-member Certification or Market Share Report, Exhibit K.

N.J.A.C. 11:20-1.2

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this chapter, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

The term "health benefits plan" specifically includes:

1. Standard health benefits plans as defined in this section;
2. Closed blocks of business otherwise meeting the definition of health benefits plan;
3. Executive medical plans;
4. Student coverage which provides more than accident-only coverages;
5. All prescription drug plans whether or not written on a stand alone basis;
6. Plans that cover both active employees and retirees eligible for Medicare for which separate statutory reporting is not made by the carrier; and
7. All other health policies, plans or contracts not specifically excluded.

"Member" means a carrier that issues or has in force health benefits plans in New Jersey. A member shall not include a carrier whose combined average Medicare and Medicaid represent enrollment represents more than 75 percent of its average total enrollment for all health benefits plans or whose combined Medicare and Medicaid net earned premium for the two-year calculation period represents more than 75 percent of its total net earned premium for the two-year calculation period. The average Medicare and Medicaid enrollment and average enrollment for all health benefits plans shall be calculated by taking the sum of these enrollment figures, as

measured on the last day of each calendar quarter during the two-year calculation period, and dividing by eight.

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, or Medicaid contracts with the State or federal government, but shall not include premiums earned from contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts.

"Non-group persons" or **"non-group persons covered"** means coverage by an individual health benefits plan or conversion policy or contract subject to P.L.1992, c.161 (N.J.S.A.17B:27A-2 et seq.), Medicare cost or risk contract, Medicare Plus Choice contract, or Medicaid contract.

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Individual Health Insurance Reform Act, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $20,000 per covered person per plan year; and

2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125 percent of expected claims per plan year.

EXHIBIT K: 1999/200
New Jersey Individual Health Coverage Program
Carrier Market Share and Net Paid Gain (Loss) Report

This Report must be completed in accordance with the provisions of N.J.A.C. 11:20-8, and certified to by the Chief Financial Officer or other duly authorized officer of the Carrier. Reports must be completed and returned on or before March 1, 2001. Completed Reports must be returned to the Executive Director, IHC Program, 20 West State Street, PO Box 325, Trenton, NJ 08625-0325.

Part A. Carrier Information

1. Carrier's Name: _____
2. Carrier's NAIC Number (including Group):_____
3. Is the specifically-named carrier an Affiliated Carrier?
_____Yes_____No
   a. If Yes, is this Report the combined Report for all Affiliated Carriers, or for the specifically named Carrier?
   _____All affiliated Carriers' combined Report
   _____Specifically Named Carrier's separate Report
   b. If for all Affiliated Carriers, list the affiliated carriers and ATTACH specifically named Carrier Reports to the combined Report.
      (i) _____
      (ii) _____
      (iii) _____
      (iv) _____
      (v) _____

4. Is this a revised report intended to replace a previously submitted Exhibit K?
   If yes, please give the date of the previously filed submission(s) and explain the reason for the revised filing.
   Date of previous filing: _____
   Reason for revised filing: _____
   _____

Part B. Personal Respondent Information

1. Name (print or type):_____
2. Title:_____
3. Telephone No.:_____ Facsimile No.:_____
   Email address:_____
4. Mailing Address: _____
   _____
   _____

Part C. Information for Two-Year Calculation Period for calendar years 1999/2000

1. Net Earned Premium (which includes all individual, group, Medicaid, and Medicare cost and risk premiums, and Medicare Plus Choice premiums, but excludes FEHBA premium, Medicare supplement, and Medicare payments received from HCFA for Medicare Plus Choice enrollees. See N.J.A.C. 11:20-1.2 for a complete description).
   a. Net Earned Premium for the first year in two-year calculation period: _____
   b. Net Earned Premium for the second year in two-year calculation period: _____
   c. Total Net Earned Premium for the two-year calculation period (C1a Plus C1b = C1c): _____

2. Number of non-group persons enrolled by the Carrier:
   For a through d below, provide the number of covered lives as of the end of each calendar quarter during the Two-Year Calculation Period, and the total for each quarter.
   a. Community rated persons — Two-year totals:
      Q1 _____ Q2 _____ Q3 _____ Q4 _____
      Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____
   b. Community rated conversion policy persons
      Q1 _____ Q2 _____ Q3 _____ Q4 _____
      Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____
   c. Medicaid recipients
      Q1 _____ Q2 _____ Q3 _____ Q4 _____
      Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____
   d. Medicare cost and risk lives
      Q1 _____ Q2 _____ Q3 _____ Q4 _____
      Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____
   e. Medicare Plus Choice lives
      Q1 _____ Q2 _____ Q3 _____ Q4 _____
      Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____
   f. Two-Year non-group total _____
   g. Average non-group enrollment (line f divided by 8): _____

3. Net paid gain (loss) report for community rated Individual Health Benefits Plans:
   a. PREMIUM EARNED $_____
   b. CLAIMS PAID $_____
   c. NET INVESTMENT INCOME $_____
   d. NET PAID GAIN LOSS
      115% (C3a Plus C3c) -C3b $_____

_____ Exempt carrier, not eligible for reimbursement
_____ Non-exempt carrier, seeking reimbursement of net paid loss shown in C3d above

Part D. Certification

I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provisions of N.J.A.C. 11:20-8.

_____ _____ _____

Signature Title Date

THE NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM
1999/2000 CERTIFICATION OF NON-MEMBER STATUS

Carrier Name: _____
Name: _____

Address: _____

_____

NAIC #: _____

I, (print or type name)_____, a duly authorized officer of the above named entity, hereby certify that this entity:

(CHECK # 1, #2 or #3)

_____1. Is not a "carrier" authorized to issue "health benefits plans" in New Jersey, as those terms are defined at N.J.A.C. 11:21-1.2;

_____ 2. Is not a "member" of the New Jersey Individual Health Coverage Program because it is a carrier whose combined average Medicare and Medicaid enrollment represents more than 75 percent of its average enrollment for all health benefits, or whose combined Medicare and Medicaid net earned premium for the two-year calculation period represents more than 75 percent of its total net earned premium for the two-year calculation period. The average Medicare and Medicaid enrollment and average enrollment for all health benefits plans shall be calculated by taking the sum these enrollment figures, as measured on the last day of each calendar quarter during the two-year calculation period, and dividing by eight; or

_____3. Is a carrier that is not a "member' of the New Jersey Individual Health Coverage Program because it has not issued nor had in force in the 1999/2000 two-year assessment cycle a "health benefits plan," as defined at N.J.A.C. 11:20-1.2, which term includes all group, as well as individual, health coverage. The accident and health premium reported to the New Jersey Department of Banking and Insurance by this carrier for the 1999/2000 two-year assessment cycle was entirely attributable to the following types of coverage, all of which are not included in, or are expressly excluded from, the definitions of "health benefits plan," "individual health benefits plan," and "net earned premium" in the rule cited above. **IN THE SPACES BELOW, LIST THE TYPES OF COVERAGES WHICH MAKE UP THE CARRIER'S REPORTED A&H PREMIUM:**

1._____
2._____
3._____
4._____
5._____

IF YOU HAVE QUESTIONS ABOUT THIS FORM, CALL (609) 633-1882, ext. 50306.

Signature of officer_____ Date: _____

Title_____ Telephone _____ Fax: _____
E-mail: _____

MAIL COMPLETED FORM TO: New Jersey Individual Health Coverage Program

PO Box 325, Trenton, NJ 08625-0325

The following excerpts from the **SEH Program** regulations are set forth below to assist you in completion of the Non-member Certification or Market Share Report, Exhibit CC.

N.J.A.C. 11:21-1.2

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this chapter, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital or medical services corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19), or any other similar contract, policy or plan issued to a small employer not explicitly excluded from the definition of health benefits plan. For purposes of this Act, "Health benefits plan" shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. 1395(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk, as

determined by the commissioner and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

"Member" means a carrier that issues health benefits plans in New Jersey on or after November 30, 1992.

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two eligible employees on the first day of the plan year, and the majority of the eligible employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. s. 414) shall be treated as one employer. Subsequent to the issuance of a health benefits plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of P.L. 1992, c.162 (N.J.S.A. 17B:27A-17 et seq.) that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in P.L. 1992, c.162 (N.J.S.A. 17B:27A-17 et seq.) to an employer shall include a reference to any predecessor of such employer.

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Small Employer Health Benefits Act, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than **$20,000 per covered person** per plan year; and

2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than **125 percent** of expected claims per plan year.

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity nonexpense incurred basis.

EXHIBIT CC: 2000

New Jersey Small Employer Health Benefits Program
Carrier Small Employer Market Share Report

This report must be completed in accordance with the provisions of N.J.A.C. 11:21-10, and certified by the Chief Financial Officer or other duly authorized officer of the Carrier. This revised report must be completed and returned on or before **March 1, 2001.** Completed Reports must be returned to: SEH Program, 20 West State Street, PO Box 325, Trenton, NJ 08625.

Part A. Carrier Information

1. Carrier's Name: _____
2. Carrier's NAIC Number: _____
3. Is the above named Carrier an affiliated Carrier?
   ____ Yes ____ No

a. If Yes, please list all Carriers with whom the above named Carrier is affiliated. List only those affiliates that had group health benefits plans in force for small employers in the preceding calendar year.

Name NAIC #

_____
_____
_____
_____

Part B. Personal Respondent Information

1. Name:_____
2. Title: _____
3. Mailing Address: _____
   _____
4. Telephone No.: _____ FAX No.: _____

Part C. Calendar Year Information for 2000

Net earned premium for all small employer group health benefits plans in 2000: $ _____
Less refunds paid in 2000 $ _____
ASSESSABLE NET EARNED PREMIUM $ _____

Part D. Certification

I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provisions of N.J.A.C. 11:21-10.

_____ _____ _____
Signature **Title** **Date**

THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM

2000 CERTIFICATION OF NON-MEMBER STATUS

Carrier
Name_____

Address_____

_____

NAIC #_____

I, (print or type name)_____, a duly authorized officer of the above named entity, hereby certify that this entity:

(CHECK EITHER # 1 OR #2)

_____1. Is not a "carrier" authorized to issue "health benefits plans" in New Jersey, as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17; **or**

_____2. Is a carrier that is not a "member' of the New Jersey Small Employer Health Benefits Program because it had no "health benefits plan" inforce in 2000 covering a New Jersey "small employer," as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17. The accident and health premiums reported to the New Jersey Department of Banking and Insurance by this carrier for 2000 were entirely attributable to the following types of coverage, all of which are not included in, or are expressly excluded from, the definition of "health benefits plan" in the rule cited above:
(IF YOU CHECKED #2, YOU MUST, IN THE SPACES BELOW, SHOW WHY THE REPORTED A&H PREMIUM IS NOT SUBJECT TO ASSESSMENT IN ORDER FOR THIS CERTIFICATION TO BE APPROVED, BY LISTING THE COVERAGE TYPES WHICH MAKE UP THE ACCIDENT AND HEALTH PREMIUM):

1._____
2._____
3._____
4._____
5._____

PLEASE NOTE: CARRIERS THAT COVER NEW JERSEY SMALL EMPLOYERS THROUGH ASSOCIATIONS, TRUSTS, OR MULTIPLE EMPLOYER ARRANGEMENTS ARE MEMBERS OF THE PROGRAM SUBJECT TO ASSESSMENT. IF YOU HAVE QUESTIONS ABOUT THIS FORM, CALL (609) 633-1882, ext. 50306.

Signature of officer_____ Date_____

Title_____ Telephone Number_____

Fax Number_____

MAIL COMPLETED FORM TO: New Jersey Small Employer Health Benefits Program
20 West State, Street, PO Box 325
Trenton, NJ 08625-0325